



THE PHYSICIAN'S *Bookshelf*

PROGRESS IN THE TREATMENT OF FRACTURES AND DISLOCATIONS — 1950-1960 — Thomas B. Quigley, M.D., Assistant Clinical Professor of Surgery, Harvard Medical School; Surgeon, Peter Bent Brigham Hospital; and Henry Banks, M.D., Clinical Associate in Orthopedic Surgery, Harvard Medical School; Associate in Orthopedic Surgery, Peter Bent Brigham Hospital. W. B. Saunders Company, Philadelphia, 1960. 102 pages, \$2.50.

Over 400 articles were selected for this 100-page review. The first 10 pages are devoted to a discussion of the general principles in the treatment of all fractures. There has been increasing attention to rehabilitation of the patient. More open reductions are being done, the quality of metallic inserts has been improved, there is much more extensive use of intramedullary splinting with corresponding decrease in the number of plates used. Replacement parts except for the head of the femur have practically disappeared. Antibiotics are no substitute for good surgical technique. Most fractures can be successfully treated by closed reduction and splinting. The decade witnessed the first unsuccessful attempt to use "bone glue." No advance has been made in our attempts to shorten the healing time either of soft tissue wounds or of fractures.

The main portion (70 pages) of the small volume deals with specific fracture problems beginning with the clavicle and ending with the bones of the foot. It is now obvious that the problem of habitual dislocation of the shoulder has been solved. There is still no completely satisfactory solution for the comminuted fracture dislocation of the shoulder joint. Contrary to some statements in text books, certain types of fractures of the humerus can be difficult. The so-called hanging arm cast, especially when used in elderly, weak muscled people, can result in distraction and nonunion. Early active motion is accented in the articles on injuries to the elbow joint. The indications and contraindications for operation in fracture of the radial head are clearly defined. The authors have recently treated 12 "shattered" elbows by open reduction with results "good enough to justify continuation of the clinical study."

For fractures of the forearm bones (adult) most authors are now recommending open reduction and internal fixation with marrow rods and addition of cancellous bone grafts at the fracture site. A long arm plaster cast for 12 to 16 weeks is essential. During the past 10 years there has been greater interest in hand injuries. More surgeons have learned the principles involved in their treatment but little if any change or advance has been made. This last statement can also be made about the treatment of spinal injuries.

For intracapsular fracture of the hip in younger people internal fixation is still the method of choice but many orthopedic surgeons are now doing primary prosthetic replacement operations in those of 70 or older. For complications such as irreducibility, nonunion and aseptic necrosis the prostheses have been successful in a high percentage of cases. Practically all orthopedic surgeons writing on fractures in and around the hip are now recommending internal fixation for intertrochanteric fractures.

Probably one of the greatest advances during the past 10 years is the clarification of the indications and techniques for the treatment of fractures of the shaft of the femur by intramedullary fixation. A number of excellent papers on this subject are reviewed.

During this same decade the enthusiasm for complete patellectomy has cooled somewhat, while at the same time it seems well established that when the internal collateral ligament is torn probably the anterior cruciate and internal meniscus are also involved and prompt surgical repair is in order.

A number of papers on open reduction treatment of tibial fractures (both bones) with insertion of various metallic devices have appeared. I think the authors' confusion about the treatment of these fractures is well exemplified by their statement, "It is to be hoped that the next progress report ten years hence will present a clearer definition of the indications and contraindications for the various methods of management of this common, difficult and treacherous fracture problem."

The decade has also seen an even firmer realization that the fractured ankle must be restored to perfect position if a satisfactory result is to be anticipated. The number of open reductions has increased enormously. Another important point has been the repeated stressing of the necessity for a long above-the-knee cast if displacement is to be prevented.

Finally the authors point out that some 10 years ago many hospitals were enthusiastically establishing bone banks but this interest has waned considerably. The patient's own bone is best.

This review is an invaluable contribution. It permits the busy surgeon to review in an hour or two the best that was written on fractures during the past decade. The articles reviewed have been well selected, the reviews are written in an interesting style, and above all one gets the opinions of the authors, obviously men of great experience and stature in this field.

DON KING, M.D.

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PROTEIN AND AMINO ACID REQUIREMENTS IN EARLY LIFE—L. Emmett Holt, Jr., M.D., Department of Pediatrics, New York University; Paul György, M.D., Department of Pediatrics, University of Pennsylvania; Edward L. Pratt, M.D., Department of Pediatrics, University of Texas; Selma E. Snyderman, M.D., Department of Pediatrics, New York University; and William M. Wallace, M.D., Department of Pediatrics, Western Reserve University. New York University Press, Washington Square, New York 3, N. Y., 1960. 63 pages, \$1.00 paper edition.

Students of nutrition, rather than clinicians, will find this evaluation of our present knowledge concerning protein and amino acid requirements in infancy and early childhood of interest. It is also hopefully aimed at the industry which has largely taken over the responsibility for giving dietary advice in these years. Minimal and optimal requirements are dealt with, as well as potential results of excessive feeding of protein. The picture of clinical protein deficiency, kwashiorkor, is also presented.